Dr Kershaw's Hospice, Turf Lane.
Royton, Oldham, OL2 6EU

HOSPICE AT HOME REFERRAL FORM

Please complete each section clearly and concisely. If you need more space, please use the additional sheet provided.

Please email to: drkh.home@nhs.net

We can no longer accept fax referrals. Assistance is available on 07856 514895

PATIENT DETAILS

Surname:		NHS No:	
First Name:		Date of Birth:	
Address:		Gender:	
		Current location of patient:	
Postcode:			
GP Practice:			
For queries who do we contact? (Name, role & tel):			

REASON FOR REFERRAL

We care for patients in the final days of life, generally limited to a 2-week duration so that we remain responsive to urgent palliative care needs.

CARE IN THE FINAL DAYS OF LIFE

(please tick all that apply)

- ☐ In my clinical judgment, I estimate that this patient's prognosis is likely to be very short (two weeks or less).
- ☐ The patient's Preferred Place of Death (PPD) is home.
- ☐ The patient and/or the carer(s) understand the purpose of this referral.
- ☐ A DNACPR decision has been made and the form is with the patient.
- ☐ Potentially futile interventions e.g. tube feeding, TPN, antibiotics etc have been reviewed, involving patient / family.
- ☐ Patient / family are aware that where patients stabilise, we will discharge them from our service.

Please describe the clinical / functional features indicating a very short prognosis:

If you have left any boxes unticked, please give further information here:

MAIN DIAGNOSIS

Primary tumour / non-malignant life limiting illness (with date of diagnosis):

Metastases (if applicable, list all sites):

PAST & PRESENT TREATMENT

Surgery (give dates):

Systemic anti-cancer therapies (chemotherapy / immunotherapy) (give dates):

Ongoing / completed when:

Radiotherapy (list all sites that have been treated) (give dates):

The current treatment intent is: ☐ curative ☐ palliative cancer treatment ☐ best supportive care

The current OACC Phase of Illness is: ☐ stable ☐ deteriorating ☐ unstable

Please leave blank if you are not familiar with OACC ☐ dying (low complexity) ☐ dying (high complexity)

MEDICAL CONTEXT

Significant past medical history:

Please list all current medication (or attach a separate list):

Please list any allergies / intolerances:

Please give the most recent eGFR result (with date):

FUNCTIONAL STATUS

	Tick the single most appropriate vaue	Duration (days)
Comatose or barely rousable.	10 ☐	
Totally bedfast and requiring extensive nursing / personal care.	20 ☐	
Almost completely bedfast.	30 ☐	
In bed more than 50% of the time.	40 ☐	
Considerable assistance and frequent medical care needed.	50 ☐	
Able to care for most needs. Requires occasional assistance.	60 ☐	
Cares for self. Unable to carry on normal activity or do active work.	70 ☐	
Normal activity with effort. Some signs or symptoms of disease.	80 ☐	
Able to carry on normal activity. Minor signs or symptoms of disease.	90 ☐	
Normal. No complaints. No evidence of disease.	100 ☐	
Oral intake	normal ☐ more than mouthfuls ☐ less than mouthfuls ☐	
Delirium	tick if present ☐	
Breathlessness at rest	tick if present ☐	
Generalised oedema	tick if present ☐	

OTHER REQUIREMENTS:

OXYGEN

Please give details of any oxygen therapy including flow rate:

SPECIAL REQUIREMENTS

Please list other requirements (e.g. TPN, NIV, tube feeding etc):

SOCIAL COMPLEXITY

Please give an outline of any social complexity. Describe care package in place (if any):

OTHER PROFESSIONALS INVOLVED	Name / Team / Cluster
☐ District Nurse	
☐ Palliative Care Nurse	
☐ Cancer Nurse Specialist	
☐ Specialist Physio / OT / Dietician	
☐ Acute Oncology	
☐ Enhanced Supportive Care	

ADDITIONAL INFORMATION

If you require more space to provide medical details, relating to the above sections, please use this Additional Information sheet. Please ensure that all relevant information is included to assist in the patient's care.

DECLARATION
☐ The patient has given consent to a this referral, OR ☐ Where a patient is found to be lacking mental capacity, a suitable process has been followed to establish that Hospice at Home is in the patient's best interest.
☐ The patient / their family are aware of the short prognosis.

REFERRER			
Name of Referrer		Position & Organisation	
Direct Tel No		Date	

This form does not require a signature.